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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: December 1, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral L4-5 transforaminal epidural steroid injection with fluoroscopy.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D., Board Certified in Neurology.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

The requested service, bilateral L4-5 transforaminal epidural steroid injection with fluoroscopy, is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated.
3. TDI Notice to IRO of Case Assignment dated 11/10/10.
4. Letter from MD dated 10/12/10.
5. Physician notes from Orthopaedic Surgery Group and Center for Sports Medicine dated 7/6/10, 5/5/10, 3/31/10, 3/25/10, 3/24/10, 2/2/10, 1/4/10, 12/16/09, 11/18/09, 10/21/09 and 9/9/09.
6. Texas Workers' Compensation Work Status Report dated 10/7/09, 9/16/09, and 9/3/09.
7. Physical therapy notes from Orthopaedic Surgery Group and Center for Sports Medicine dated 3/5/10, 3/3/10, 2/24/10, 2/22/10, 2/19/10, 2/12/10, 2/10/10, 12/24/09, 12/23/09, 12/21/09, 12/18/09, 10/30/09, 10/28/09, 10/26/09, 10/21/09, 10/19/09, 10/16/09, 10/14/09, 10/12/09, 10/7/09, and 9/9/09.
8. Procedure note from Specialty Hospital dated 5/6/10 and 3/26/10.
9. Lab report dated 2/2/10.
10. MRI of the lumbar spine without contrast dated 9/30/09.
11. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who is a maintenance worker. An injury occurred on xx/xx/xx when she fell while carrying a waste can and suffered low back pain described as being in the lumbar-radicular distribution. The diagnosis was made of a herniated disc at L4-5. The patient had degenerative changes of an arthritic nature of the lumbar spine with lumbar spondylosis but without significant nerve root compression on MRI imaging. The disc herniation in the L4-5 area was small. On physical examination, the patient had pain in the low back with some radiation down the legs but the neurological examination and nerve conduction examination by a neurologist showed no evidence of root compression or radiculopathy. Bilateral L4-5 transforaminal epidural steroid injection with fluoroscopy has been recommended. The Carrier has denied this request indicating the requested service is not medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

Bilateral L4-5 transforaminal epidural steroid injection with fluoroscopy is not medically necessary for treatment of the patient's medical condition. The submitted neurological examinations reveal no evidence of radiculopathy. There is no evidence of nerve root compression based on the clinical evidence provided. The neurological examination did not show weakness or paralysis in the nerve root described or any sensory loss. The nerve conduction times were normal and the radiographic studies showed only a small L4 herniation of the disc without any nerve root compression. The patient does not meet accepted criteria for the requested service. As such, the requested service is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)